



Prior Authorization Form

Celebrex®, Mobic®, Ultram ER®, Flector patch®, Voltaren gel®, Ryzolt®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [ ] Celebrex® [ ] Mobic® [ ] Ultram ER® [ ] Flector patch® [ ] Voltaren gel® [ ] Ryzolt®

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_
Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_
Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_
Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- [ ] Osteoarthritis [ ] Rheumatoid arthritis [ ] Familial Adenomatous Polyposis (FAP)
[ ] Other (specify) \_\_\_\_\_

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[ ] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes blank rows for entry.

3. PATIENT HISTORY: (Celebrex and Mobic only)

- a. Does the patient have sulfonamide allergy? [ ] Yes [ ] No
(Sulfa allergy is exclusionary for Celebrex and that documentation of tolerating a trial of these agents would be required for approval).
b. Does the patient have NSAIDs or aspirin allergy (i.e. ibuprofen, naproxen)? [ ] Yes [ ] No
c. Is the patient currently on an anticoagulant (i.e. warfarin) within the last 90 days? [ ] Yes [ ] No
d. Does the patient have any bleeding disorder? [ ] Yes [ ] No
e. Is the patient currently on any concurrent systemic steroid treatment? [ ] Yes [ ] No
f. Does the patient have a history of gastrointestinal bleed, peptic ulcer, GERD, or Barretts esophagus? [ ] Yes [ ] No

Please add any other supporting medical information that may be useful in the decision-making process:

\_\_\_\_\_
\_\_\_\_\_

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
Document # \_\_\_\_\_ Coverage effective date / /
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M F Rx coverage Y N STANDARD - SELECT LOB \_\_\_\_\_
Previous Auth Y N Approved Reviewer Initials \_\_\_\_\_ Date \_\_\_\_\_